Tennessee Department of Human Services Appeal

¿Habla español?
1-866-311-4290

Need help? Call your DHS worker. Or, call the Family Assistance Service Center for free at **1-866-311-4287**

Do you think there was a mistake with your Food Stamps, Families First, TennCare Medicaid or TennCare Standard? You can appeal. An appeal is one way to fix mistakes. You can use this paper to appeal. This paper is **only for appeals** about Food Stamps, Families First, TennCare Medicaid or TennCare Standard. **Don't use this paper for anything else.**

- Need to **apply** for Food Stamps, Families First, TennCare Medicaid or TennCare Standard? (Only children under age 19 who are losing Medicaid may get TennCare.) Get a DHS application.
- Need to **report a change** (such as a new address or change in jobs or income)? Call the Family Assistance Service Center at **1-866-311-4287**. In Nashville, call **743-2000.** They're open Monday through Friday, 7:00 a.m. to 5:30 p.m.
- Need to **change your TennCare health plan** (MCO)? Or, need **help getting health care or medicine?** Don't use this paper. Call TennCare Solutions at **1-800-878-3192.** Need **other help**? Ask your DHS worker. **OR,** call the Family Assistance Service Center at **1-866-311-4287.**

How long do you have to appeal?

For Families First and Food Stamps: You have **90 days** to appeal. The 90 days start **the day after the date on the letter** you got from DHS. (It's the letter that told you whatever it is that you're appealing about.) **Are you getting Food Stamps or Families First now? Do you want to keep them during your appeal?** You must appeal within **10 days**. The 10 days start **the day after the date on the letter** from DHS.
What if you lose your appeal? **You will have to pay back the Food Stamps or Families First benefits** you get during your appeal.

For TennCare Medicaid and TennCare Standard: You have **40 days** to appeal. The 40 days start the **day after the date on the letter** from DHS or TennCare. (It's the letter that told you whatever it is that you're appealing about.) **Are you getting TennCare Medicaid or TennCare Standard now? Do you want to keep getting it during your appeal?** You must appeal within **20 days OR** before your TennCare Medicaid or TennCare Standard ends (if that date is later). The 20 days start the day after the date on the letter from DHS or TennCare. What if you lose your appeal? **You will have to pay TennCare back** for health care or medicine you get during your appeal.

Mail your appeal to: Tennessee Department of Human Services
Division of Appeals and Hearings
PO Box 198996
OR, fax it to: Nashville, TN 37219-8996
1-866-355-6136

Keep a copy of the appeal and the page that says your fax went through.

Tell us about the person who is appealing:

1. Who has the problem you are appealing about? (Print their full name.)
First Name: _____ Middle Initial _____ Last Name: _____

2. Social Security Number: ___ - ___ - _____ **3.** Date of Birth: _____

4. Who else in your household has the same problem? Tell us their name(s).

_____

_____

5. What is your daytime phone number? ( ) -

6. What is your nighttime phone number? ( ) -

7. Is there another number where we can call you? ( ) -

8. What is the best time of day to call you? _____

9. E-mail address: _____

10. Full Mailing Address (Be sure to put Apt. Number, PO Box Number, Street Number, Lot Number -- and **be sure to let DHS know if it changes**.)
Address: _____
City: _____ State: _____ Zip Code: _____

Tell us about your appeal.

11. What are you appealing about? (You can mark more than one.)

☐ Families First ☐ Food Stamps ☐ TennCare Medicaid ☐ TennCare Standard

Tell us as many facts as you can about the problem. You can add more pages.

_____

_____

Do you have any proof of what you say? Then send a copy with this paper.

12. **IF** your appeal is for Families First or Food Stamps, **check one of the boxes below.**

☐ **Keep my Families First/Food Stamps going** until my appeal is decided. If I lose the appeal, I know that I may have to pay it back.

☐ **Stop my Families First/Food Stamps** until my appeal is decided. If I win the appeal, the state may owe me money.

You must tell us if you want to keep them or stop them during your appeal.

13. Sign here: _____ **14. Today's date**: _____
(Person appealing or authorized person who signs for them.)

Complete this part IF you are helping someone else fill out this paper.

15. Name: _____ Day time phone: ( ) -

How do you know the person who is appealing: Are you their:
☐ Parent ☐ Relative ☐ Friend ☐ Legal Guardian or Conservator
☐ Doctor/Medical Staff ☐ Interpreter/Translator ☐ Advocate
☐ Authorized Representative ☐ Other (describe)

DHS will fill out this box:		**Date Received:**	
DHS Caseworker:		**User ID:**	
DHS FS 1		**User ID:**	